Senate

General Assembly

File No. 410

February Session, 2018

Substitute Senate Bill No. 511

Senate, April 10, 2018

The Committee on Public Health reported through SEN. GERRATANA of the 6th Dist. and SEN. SOMERS of the 18th Dist., Chairpersons of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING OPIOIDS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (*Effective from passage*) (a) The Commissioner of Mental Health and Addiction Services, in collaboration with the Chief Medical Examiner and the Insurance Commissioner, shall convene a working group to evaluate methods of combating the opioid epidemic in the state. The working group shall consist of the Commissioner of Mental Health and Addiction Services, or the commissioner's designee, the Chief Medical Examiner, or the Chief Medical Examiner's designee, the Insurance Commissioner, or the commissioner's designee, and at least eight other members selected by the Commissioner of Mental Health and Addiction Services, who have experience in one or more of the following: (1) Opioid use disorder and the treatment thereof, (2) substance use disorder and the treatment thereof, (3) administration of a methadone treatment program, (4) administration of a substance use disorder treatment program, (5) dispensing and administering opioid

antagonists, and (6) insurance coverage for substance use disorder treatment programs. The Commissioner of Mental Health and Addiction Services shall elect a chairperson of the working group from among its members.

(b) The working group shall investigate and advise the Commissioner of Mental Health and Addiction Services regarding the following:

(1) The number of persons annually who receive services from each methadone treatment program funded by contract with the Department of Mental Health and Addiction Services, the rate at which such persons relapse and the number of such persons who die while participating in such program;

(2) The availability of opioid antagonists, as defined in section 17a-714a of the general statutes, at each such methadone treatment program and each state-funded treatment program for persons with substance use disorder;

(3) The advantages and disadvantages of a licensed mental health professional at each such methadone treatment program and each treatment program for persons with substance use disorder being permitted to dispense an opioid antagonist directly to a person at the time of such person's discharge from such program without the need for such person to obtain the opioid antagonist from a pharmacy under section 20-633c or 20-633d of the general statutes;

(4) Whether a nonfatal drug overdose at a hospital or outpatient surgical facility should qualify as an adverse event under section 19a-127n of the general statutes;

(5) The role of health carriers, as defined in section 19a-755b of the general statutes, in shortening a person's stay at a treatment program for persons with substance use disorder;

(6) The availability of federal funds to supply emergency medical services personnel in the state with opioid antagonists and provide

training to such personnel in the administration of opioid antagonists; and

(7) The development and implementation of a state-wide uniform prehospital data reporting system to capture the demographics of prehospital administration or use of an opioid antagonist and opioid reversal outcomes as a result of such administration or use.

(c) On or before January 1, 2019, the chairperson of the working group shall report the findings of the working group to the Commissioner of Mental Health and Addiction Services. The commissioner shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding such findings and any recommendations for legislation.

Sec. 2. Subsection (j) of section 21a-254 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(j) (1) The commissioner shall, within available appropriations, establish an electronic prescription drug monitoring program to collect, by electronic means, prescription information for schedules II, III, IV and V controlled substances that are dispensed by pharmacies, nonresident pharmacies, as defined in section 20-627, outpatient pharmacies in hospitals or institutions or by any other dispenser. The program shall be designed to provide information regarding the prescription of controlled substances in order to prevent the improper or illegal use of the controlled substances and shall not infringe on the legitimate prescribing of a controlled substance by a prescribing practitioner acting in good faith and in the course of professional practice.

(2) The commissioner may identify other products or substances to be included in the electronic prescription drug monitoring program established pursuant to subdivision (1) of this subsection.

(3) Prior to July 1, 2016, each pharmacy, nonresident pharmacy, as defined in section 20-627, outpatient pharmacy in a hospital or institution and dispenser shall report to the commissioner, at least weekly, by electronic means or, if a pharmacy or outpatient pharmacy does not maintain records electronically, in a format approved by the commissioner, the following information for all controlled substance prescriptions dispensed by such pharmacy or outpatient pharmacy: (A) Dispenser identification number; (B) the date the prescription for the controlled substance was filled; (C) the prescription number; (D) whether the prescription for the controlled substance is new or a refill; (E) the national drug code number for the drug dispensed; (F) the amount of the controlled substance dispensed and the number of days' supply of the controlled substance; (G) a patient identification number; (H) the patient's first name, last name and street address, including postal code; (I) the date of birth of the patient; (J) the date the prescription for the controlled substance was issued by the prescribing practitioner and the prescribing practitioner's Drug Enforcement Agency's identification number; and (K) the type of payment.

(4) (A) Except as provided in this subdivision, on and after July 1, 2016, each pharmacy, nonresident pharmacy, as defined in section 20-627, outpatient pharmacy in a hospital or institution, and dispenser shall report to the commissioner by electronic means, in a format approved by the commissioner, the following information for all controlled substance prescriptions dispensed by such pharmacy or outpatient pharmacy immediately upon, but in no event later than the next business day after, dispensing such prescriptions: (i) Dispenser identification number; (ii) the date the prescription for the controlled substance was filled; (iii) the prescription number; (iv) whether the prescription for the controlled substance is new or a refill; (v) the national drug code number for the drug dispensed; (vi) the amount of the controlled substance dispensed and the number of days' supply of the controlled substance; (vii) a patient identification number; (viii) the patient's first name, last name and street address, including postal code; (ix) the date of birth of the patient; (x) the date the prescription for the controlled substance was issued by the prescribing practitioner

and the prescribing practitioner's Drug Enforcement Agency's identification number; and (xi) the type of payment.

(B) If the electronic prescription drug monitoring program is not operational, such pharmacy or dispenser shall report the information described in this subdivision not later than the next business day after regaining access to such program. For purposes of this subdivision, "business day" means any day during which the pharmacy is open to the public.

(C) Each veterinarian, licensed pursuant to chapter 384, who dispenses a controlled substance prescription shall report to the commissioner the information described in subparagraph (A) of this subdivision, at least weekly, by electronic means or, if the veterinarian does not maintain records electronically, in a format approved by the commissioner.

(5) The commissioner may contract with a vendor for purposes of electronically collecting such controlled substance prescription information. The commissioner and any such vendor shall maintain the information in accordance with the provisions of chapter 400j.

(6) The commissioner and any such vendor shall not disclose controlled substance prescription information reported pursuant to subdivisions (3) and (4) of this subsection, except as authorized pursuant to the provisions of sections 21a-240 to 21a-283, inclusive. Any person who knowingly violates any provision of this subdivision or subdivision (5) of this subsection shall be guilty of a class D felony.

(7) The commissioner shall provide, upon request, controlled substance prescription information obtained in accordance with subdivisions (3) and (4) of this subsection to the following: (A) The prescribing practitioner or such practitioner's authorized agent, who is treating or has treated a specific patient, provided the information is obtained for purposes related to the treatment of the patient, including the monitoring of controlled substances obtained by the patient; (B) the prescribing practitioner with whom a patient has made contact for the

purpose of seeking medical treatment or such practitioner's authorized agent, provided the request is accompanied by a written consent, signed by the prospective patient, for the release of controlled substance prescription information; or (C) the pharmacist who is dispensing controlled substances for a patient, provided the information is obtained for purposes related to the scope of the pharmacist's practice and management of the patient's drug therapy, including the monitoring of controlled substances obtained by the patient. The prescribing practitioner, such practitioner's authorized agent, or the pharmacist shall submit a written and signed request to the commissioner for controlled substance prescription information. Such prescribing practitioner or pharmacist shall not disclose any such request except as authorized pursuant to sections 20-570 to 20-630, inclusive, or sections 21a-240 to 21a-283, inclusive.

(8) No person or employer shall prohibit, discourage or impede a prescribing practitioner or pharmacist from requesting controlled substance prescription information pursuant to this subsection.

(9) Prior to prescribing greater than a seventy-two-hour supply of any controlled substance to any patient, the prescribing practitioner or such practitioner's authorized agent shall review the patient's records in the electronic prescription drug monitoring program established pursuant to this subsection. Whenever a prescribing practitioner prescribes a controlled substance, other than a schedule V nonnarcotic controlled substance, for the continuous or prolonged treatment of any patient, such prescriber, or such prescriber's authorized agent, shall review, not less than once every ninety days, the patient's records in such prescription drug monitoring program. Whenever a prescribing practitioner prescribes a schedule V nonnarcotic controlled substance, for the continuous or prolonged treatment of any patient, such prescribing practitioner, or such prescribing practitioner's authorized agent, shall review, not less than annually, the patient's records in such prescription drug monitoring program. If such electronic prescription drug monitoring program is not operational, such prescribing practitioner may prescribe greater than a seventy-two-hour supply of a

controlled substance to a patient during the time of such program's inoperability, provided such prescribing practitioner or such authorized agent reviews the records of such patient in such program not more than twenty-four hours after regaining access to such program.

(10) (A) A prescribing practitioner may designate an authorized agent to review the electronic prescription drug monitoring program and patient controlled substance prescription information on behalf of the prescribing practitioner. The prescribing practitioner shall ensure that any authorized agent's access to such program and patient controlled substance prescription information is limited to the purposes described in this section and occurs in a manner that protects the confidentiality of information that is accessed through such program. The prescribing practitioner and any authorized agent shall be subject to the provisions of 45 CFR 164.308, as amended from time to time, concerning administrative safeguards for the protection of electronic protected health information. A prescribing practitioner may receive disciplinary action for acts of the authorized agent as provided in section 21a-322.

(B) Notwithstanding the provisions of subparagraph (A) of this subdivision, a prescribing practitioner who is employed by or provides professional services to a hospital shall, prior to designating an authorized agent to review the electronic prescription drug monitoring program and patient controlled substance prescription information on behalf of the prescribing practitioner, (i) submit a request to designate one or more authorized agents for such purposes and a written protocol for oversight of the authorized agent or agents to the commissioner, in the form and manner prescribed by the commissioner, and (ii) receive the commissioner's approval to designate such authorized agent or agents and of such written protocol. Such written protocol shall designate either the hospital's medical director, a hospital department head, who is a prescribing practitioner, or another prescribing practitioner as the person responsible for ensuring that the authorized agent's or agents' access to

such program and patient controlled substance prescription information is limited to the purposes described in this section and occurs in a manner that protects the confidentiality of information that is accessed through such program. A hospital medical director, a hospital department head, who is a prescribing practitioner, or another prescribing practitioner designated as the person responsible for overseeing an authorized agent's or agents' access to such program and information in the written protocol approved by the commissioner may receive disciplinary action for acts of the authorized agent or agents as provided in section 21a-322. The commissioner may inspect hospital records to determine compliance with written protocols approved in accordance with this section.

(11) Prior to dispensing an opioid drug, as defined in section 20-14o, to any patient, the pharmacist shall review the patient's record in the electronic prescription drug monitoring program for purposes related to the scope of the pharmacist's practice and management of the patient's drug therapy, including the monitoring of controlled substances obtained by the patient.

[(11)**]** (12) The commissioner shall adopt regulations, in accordance with chapter 54, concerning the reporting, evaluation, management and storage of electronic controlled substance prescription information.

[(12)**]** (13) The provisions of this section shall not apply to (A) samples of controlled substances dispensed by a physician to a patient, or (B) any controlled substances dispensed to hospital inpatients.

[(13)**]** (14) The provisions of this section shall not apply to any institutional pharmacy or pharmacist's drug room operated by a facility, licensed under section 19a-495 and regulations adopted pursuant to said section 19a-495, that dispenses or administers directly to a patient an opioid agonist for treatment of a substance use disorder.

[(14)**]** (15) The commissioner may provide controlled substance prescription information obtained in accordance with subdivisions (3)

and (4) of this subsection to other state agencies, pursuant to an agreement between the commissioner and the head of such agency, provided the information is obtained for a study of disease prevention and control related to opioid abuse or the study of morbidity and mortality caused by overdoses of controlled substances. The provision of such information shall be in accordance with all applicable state and federal confidentiality requirements.

Sec. 3. (NEW) (*Effective July 1, 2018*) (a) Any hospital, emergency medical services provider, health care provider or mental health care professional who treats a patient for an overdose of an opioid drug, as defined in section 20-14o of the general statutes, shall, subject to the limitation set forth in subsection (b) of this section, report such overdose to the municipal health department or district department of health that has jurisdiction over the location in which such overdose occurred or, if such location is unknown, the location in which such provider treated such patient. A municipal health department and district department of health that receives a report of an opioid drug overdose under this section shall use the information contained in such report to develop preventative initiatives on a local level to address the incidences of opioid drug overdoses occurring throughout the state.

(b) No hospital or provider shall disclose personally identifiable information in reporting an opioid drug overdose pursuant to this section.

(c) Information collected by a municipal health department or district department of health pursuant to this section shall not be (1) disclosed pursuant to subsection (a) of section 1-210 of the general statutes at any time, or (2) subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding except as otherwise specifically provided by law.

Sec. 4. (*Effective July 1, 2018*) The sum of twenty-five million dollars is appropriated to the Department of Mental Health and Addiction Services, from the General Fund, for the fiscal year ending June 30, 2019, for the purpose of providing funding for screening of, early

intervention for and referral to treatment of persons with opioid use disorder.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*January 1, 2019*	21a-254(j)
Sec. 3	*July 1, 2018*	New section
Sec. 4	*July 1, 2018*	New section

PH *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 19 $	FY 20 $
Mental Health & Addiction Serv., Dept.	GF - Cost	25 million	See Below
Consumer Protection, Dept.	GF - Cost	152,095	152,095
State Comptroller - Fringe Benefits[1]	GF - Cost	50,983	50,983
Consumer Protection, Dept.	GF - Potential Revenue Gain	See Below	See Below

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 19 $	FY 20 $
Various Municipalities	STATE MANDATE - Cost	Potential	Potential

Explanation

Section 1 of the bill requires the Department of Mental Health and Addiction Services (DMAS), in collaboration with the Chief Medical Examiner and the Insurance Commissioner, to establish a working group to evaluate methods of combating the opioid epidemic in Connecticut, which is not anticipated to result in a fiscal impact as the agencies currently have the expertise to do so.

Section 2 requires pharmacists to review patient's records in the

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 36.33% of payroll in FY 19 and FY 20.

electronic prescription drug monitoring program and results in a cost and potential revenue gain to the state. There are currently 5,845 pharmacists in the state who will now have to use the electronic drug monitoring program, which is monitored for compliance by the Department of Consumer Protection (DCP). In order to adequately monitor compliance, DCP will need to hire a drug control agent ($84,405 salary and $30,664 fringe benefits) and Health Program Assistant ($55,928 salary and $20,319 fringe benefits) with combined other expenses costs of $11,762.

The bill results in a potential revenue gain to the extent that pharmacists do not comply with the bill and are fined up to $1,000 by DCP.

Section 3 requires municipalities to implement initiatives designed to reduce opioid use. There is a potential cost to municipalities that will vary based on the types of initiatives they choose to implement.

Section 4 appropriates $25 million to the Department of Mental Health and Addiction Services (DMHAS) in FY 19 to support screening and early intervention and treatment services for individuals with opioid use disorder. If services are continued in FY 20 it will result in a cost to DMHAS. The bill does not specify funding or service provision requirements in FY 20 or beyond.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sSB 511

AN ACT CONCERNING OPIOIDS.

SUMMARY

This bill contains various provisions on the prevention and treatment opioid abuse. It:

1. requires the Department of Mental Health and Addiction Services (DMHAS), in collaboration with the chief medical examiner and insurance commissioner, to convene a working group to evaluate and report on ways to combat Connecticut's opioid epidemic (§ 1);

2. requires pharmacists, before dispensing an opioid drug, to review the patient's record in the state's electronic prescription drug monitoring program (§ 2);

3. requires hospitals and specified providers who treat individuals for an opioid drug overdose to report non-personally identifiable information on the overdoses to local health departments (§ 3); and

4. appropriates $25 million from the General Fund to DMHAS in FY 19 to fund screening, early intervention, and treatment referrals for people with opioid use disorder (§ 4).

EFFECTIVE DATE: July 1, 2018, except that the provisions on the (1) opioid working group take effect upon passage and (2) prescription drug monitoring program take effect January 1, 2019.

§ 1 — OPIOID WORKING GROUP

The bill requires the DMHAS commissioner to collaborate with the chief medical examiner and insurance commissioner and convene a

working group to evaluate ways to combat the state's opioid epidemic.

Membership

Under the bill, working group members include the chief medical examiner and the DMHAS and insurance commissioners, or their designees, and at least eight other members the DMHAS commissioner selects who have experience in at least one of the following:

1. opioid use disorder and its treatment,
2. substance use disorder and its treatment,
3. administering a methadone treatment program,
4. administering a substance use disorder treatment program,
5. dispensing and administering opioid antagonists, or
6. insurance coverage for substance use disorder treatment programs.

The DMHAS commissioner must select the working group's chairperson from among its members.

Duties

The bill requires the working group to investigate and advise the DMHAS commissioner on:

1. how many people annually receive services from each DMHAS-contracted methadone treatment program, the relapse rate, and the number of participant deaths;
2. the availability of opioid antagonists at each (a) DMHAS-contracted methadone treatment program and (b) state-funded substance use disorder treatment program;
3. advantages and disadvantages of allowing licensed mental health professionals at methadone treatment programs and substance use disorder treatment programs to dispense an

opioid antagonist directly to a person at the time of his or her discharge from the program so that he or she does not have to obtain the medication from a pharmacy;

4. whether a nonfatal drug overdose at a hospital or outpatient surgical facility should qualify as an adverse event reportable to the Department of Public Health;

5. the role of health carriers (e.g., insurers or HMOs) in shortening a person's stay at a substance use disorder treatment program;

6. the availability of federal funds to supply EMS personnel with opioid antagonists and training in how to administer them; and

7. developing and implementing a state-wide, uniform prehospital data reporting system to capture the demographics of (a) prehospital administration or use of opioid antagonists and (b) overdose reversal outcomes resulting from their administration or use.

Reporting

The bill requires the chairperson, by January 1, 2019, to report the working group's findings to the DMHAS commissioner, who must then report these findings and any legislative recommendations to the Public Health Committee.

§ 2 — PRESCRIPTION DRUG MONITORING PROGRAM

The bill requires pharmacists, before dispensing an opioid drug to a patient, to review the patient's record in the Department of Consumer Protection's electronic prescription drug monitoring program (PDMP). They must do this for purposes related to their scope of practice and management of the patient's drug therapy, including monitoring the patient's controlled substances.

Existing law also requires a prescribing practitioner, or the practitioner's authorized agent, to review a patient's records in the PDMP before prescribing more than a 72-hour supply of a controlled

substance. The practitioner or agent must also periodically review a patient's PDMP records when the practitioner prescribes controlled substances for continuous or prolonged treatment (CGS § 21a-254(j)(9)).

§ 3 — REPORTING OVERDOSE DATA TO LOCAL HEALTH DEPARTMENTS

The bill requires hospitals and emergency medical services, mental health, and health care providers who treat someone for an opioid drug overdose to report the overdose to the municipal or district health department in the location where the overdose occurred, or, if the location is unknown, the location of the treatment. But when doing so, hospitals and providers cannot disclose personally identifiable information.

Under the bill, municipal or district health departments that receive such information must use it to develop local, preventative initiatives to address opioid drug overdoses. Additionally, the bill specifies that such information is not subject to (1) disclosure under the Freedom of Information Act or (2) subpoena or discovery or introduction into evidence in any judicial or administrative proceeding unless specifically provided by law.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 26 Nay 0 (03/26/2018)